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# Conspiracy of Silence

Richard M. Markus

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## Conspiracy of Silence

Richard M. Markus\*

*Medicine is of all the arts the most noble; but, owing to the ignorance of those who practice it, and of those who, inconsiderately, form a judgment of them, it is at present far behind all the other arts. Their mistake appears to me to arise principally from this, that in the cities there is no punishment connected with the malpractice of medicine (and with it alone) except disgrace, and that does not hurt those who are familiar with it.*

THESE RATHER STRONG WORDS of criticism are those of the most distinguished physician of history—Hippocrates.<sup>1</sup> The revered Hippocratic Oath calls upon every physician to proclaim:<sup>2</sup>

Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption.

Hippocrates' concern for discipline of the medical profession by itself and by society found its cognate in the Code of Hammurabi of 1750 B. C., which provided that if a physician caused a man's death or the loss of his eye by an operation, the physician's fingers were to be cut off. If he caused the death of a slave, he was obliged to restore a slave of equal value.<sup>3</sup>

The later Justinian Code of the Romans made a similar provision, that if a surgeon operates on one's slave, and then neglects altogether to attend to his cure, or operates unskillfully, so that the slave dies in consequence, he is liable for the highest value of that slave within the preceding year.<sup>4</sup> In this country our own legal history includes the very early malpractice case of *Cross v. Guthrie*<sup>5</sup> in 1794 when a jury awarded \$120.00 for the wrongful death of the plaintiff's wife as a result of the de-

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<sup>1</sup> See, Adams, *Genuine Works of Hippocrates*, "The Law," p. 281 (1929).

<sup>2</sup> See, *Id.*, "The Oath," p. 280.

<sup>3</sup> See, Allen, *Evolution of Governments and Laws*, "Code of Hammurabi," Sec. 210, p. 1001 (1916); Oleck, *Damages to Persons & Property*, 4 (1961 rev. ed.).

<sup>4</sup> See, Moyle, *Institutes of Justinian*, Title III, "Of the Lex Aquila," pp. 169-70 (2nd ed. 1889).

<sup>5</sup> Mass. (unreported).

fendant-physician's malpractice. That history also includes the case of *Ritchey v. West*,<sup>6</sup> in which Abraham Lincoln unsuccessfully defended a physician against a malpractice claim in 1860, a few months before entering the White House.

If the medical societies were in fact openly exposing the errors of their fellows, one might expect that the repeatedly careless physician would be ousted from all privileges and that the attorney seeking to advance a meritorious civil damage action would receive every aid and assistance from other physicians. Regrettably, neither appears to be the case. In a survey conducted by the American Medical Association, with questionnaires to 1100 county medical societies, the AMA committee found that a total of only 21 doctors had been expelled from those societies, in the two-year interval over which the survey ran.<sup>7</sup> Of those 21 persons, only 4 doctors in the entire United States had been expelled during those two years for offenses against patients. When we compare this to the magnitude and frequency of disciplinary action against attorneys, we are induced to conclude that the medical societies are unwilling or unable to discipline their own ranks. For example, in Ohio alone, eighteen attorneys were disciplined last year; and others were induced to submit voluntary resignations from practice.<sup>8</sup>

The problem for the lawyer is exemplified by a case that arose in Cleveland which involved a young lady who sustained certain psychiatric injuries as the result of plastic surgery. The physician had blatantly advertised under "Plastics" in the Yellow Pages of the telephone directory with "before and after" nose pictures. There have been some 20 lawsuits filed against him for medical malpractice. He had no malpractice insurance and no carrier would issue any to him. The local medical society knew all these facts and held him in very low esteem. However, when counsel requested help from that society in locating a witness to testify against this man, the society refused

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<sup>6</sup> 23 Ill. 329 (1860).

<sup>7</sup> See, Carter, *The Doctor Business*, p. 122 (1958). In 1961 only one physician in the United States was expelled from a medical society, and that did not prevent him from continuing to practice. A new law is being considered in California to authorize the State Board of Medical Examiners to take licenses from physicians who are hazards to public health. See *Los Angeles Times*, March 29, 1965, pp. 1-2.

<sup>8</sup> Office of the Administrative Assistant of the Supreme Court of Ohio, "Ohio Courts," p. 1 (1964).

to make any efforts in this direction and said that it was up to each individual plastic surgeon whether he wished to testify. When no expert witness could be found, the case was tried solely on an assault and battery charge because the patient was only 18 years of age when she consented to the procedure.

Eventually even this charge was lost when the Ohio Supreme Court held that a reasonably mature minor can effectively consent to such a surgical procedure.<sup>9</sup> The aftermath of this story was not pleasant. The client manifested greater psychiatric complications. She eventually tried to shoot the doctor and was institutionalized. Several years after the case was concluded, the doctor was indicted for double manslaughter as a result of the deaths of two women in his office (over a two-week period), when he attempted surgery while under the influence of narcotics. He, too, was institutionalized.

The requirement that independent expert medical testimony establish the proper standard of care and the defendant's failure to meet that standard imposes an almost insurmountable obstacle in many cases. The so-called *conspiracy of silence* has been recognized, as a matter of judicial notice, by courts in New Jersey,<sup>10</sup> California,<sup>11</sup> and elsewhere. The use of that phrase to describe the unavailability of medical witnesses has particularly dramatic force which impresses a court and jury. However, no apt phrase could detract from the reality of this practical problem which faces an attorney representing a client seeking damages from a physician for professional negligence. This does not mean that medical testimony is always totally unavailable. If such were the case, the relatively small number of malpractice cases that are successful would be even smaller. There are a few physicians who will extend themselves to speak their true opinions forthrightly in the interest of justice. There are a few

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<sup>9</sup> *Lacey v. Laird*, 166 Ohio St. 12, 139 N. E. 2d 25, 1 Ohio Ops. 2d 158 (1956).

<sup>10</sup> *Steingra v. Thron*, 30 N. J. Super. 423, 105 A. 2d 10 (App. Div. 1954). See other cases cited at Louisell & Williams, *Trial of Medical Malpractice Cases*, Sections 14.01 and 14.02 (1960).

<sup>11</sup> *Salgo v. Leland Stanford Jr. University Bd. of Trustees*, 154 Cal. App. 2d 560, 317 P. 2d 170 (1957). As one defense counsel acknowledged, "The most obvious attack for the plaintiff is to get himself his own expert who will testify against the defendant. Despite propaganda to the contrary, this is no easy task, and the plaintiff may find it impossible unless the case borders on criminal negligence." See, *Murphy, Medical Malpractice*, 7 Defense L. J. 6-8 (1960).

circumstances in which other physicians will testify adversely to a doctor located outside of their professional or geographical community. There are still other physicians who will consult informally with plaintiff's counsel to assist in determining the technical details of a potential claim. But no attorney who has represented plaintiffs in this field of practice will deny that there is a special problem of obtaining supporting medical testimony.

This difficulty demeans both the legal and medical professions. To the extent that any non-legal force defeats or enhances a litigant's position, the legal profession loses its strength and value. To the extent that a physician is protected from the consequences of his own mistakes, the medical profession is discouraged from maintaining its established level of proficiency and competence. To the extent that essential medical witnesses are difficult to locate, the orderly processes of negotiation are hampered by an understandable reluctance of plaintiff's counsel to reveal his potential expert—for fear that the witness will be dissuaded from further cooperation. And, to the extent that both professions fail to provide a just resolution of the public's rights in these areas, public confidence in each profession suffers from a frustration related to the inability to obtain a remedy in the presence of a known right.

The seeds of a solution to this disturbing problem might be seen from an analysis of its sources. The simplest explanation, though not necessarily the most accurate, is professional pride and camaraderie of the medical profession. While a potential medical witness is naturally reluctant to speak out against a brother physician, it is doubtful that such fraternal allegiance would be sufficient to create this problem. The same interest in protecting the group likewise affects witnesses engaged in virtually every occupation and profession, to a greater or lesser extent. Scientists, lawyers, engineers, architects and other professionals are periodically called upon to testify against another member of the same profession. Despite their concern that such testimony might engender hostility or even recrimination, such other professionals do appear with some frequency in judicial proceedings. While a physician is not often heard to attack the work of another physician in public, most hospitals have committee meetings during which the mistakes of members of the staff are dissected and debated. If these mistakes are sufficiently gross or sufficiently frequent, the offending physician is in-

formally persuaded to mend his ways, to leave the hospital staff, or even to leave the medical community.

A far greater force in restraining physicians from testifying would seem to be a widespread hysteria among members of that profession. Fear that medical malpractice claims are increasing in size and frequency at an incredible rate deters every member of that profession from cooperating in such claims. Too many physicians suffer from a veritable terror that ruin and destruction lie ahead for them in the course. It is commonplace for professional medical journals to carry extended articles relating to malpractice claims, their magnitude and their oppressiveness. A recent copy of *Medical Economics*,<sup>12</sup> a widely circulated professional periodical, contains three separate articles on this subject in a single issue. Seldom is the suggestion made that a careful physician who executes his duties with dignity, knowledge, and compassion is relatively safe from any substantial damage recovery.

As a matter of fact, the American Medical Association conducted two surveys of its membership to determine the true level of medical malpractice claims. The first survey was in 1956.<sup>13</sup> Results of the more recent survey were published late last year in the *Journal of the American Medical Association*.<sup>14</sup> That article shows that only 17.8% of the physicians in active private practice in the United States have ever had any malpractice claim *asserted* against them. The 1956 survey showed almost the identical percentage of such physicians against whom claims had been made. Indeed, the percentage of physicians against whom claims had ever been made was slightly less in 1963 than in 1956.<sup>15</sup>

On the basis of presumed numbers of physician-patient visits, the AMA estimated that the proportionate risk rate of malpractice claims to patient visits is approximately 37/100,000 or 1%. The Law Department of the AMA concludes in the recent article: <sup>16</sup>

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<sup>12</sup> Vol. 42, No. 4 (Feb. 22, 1965).

<sup>13</sup> For an analysis of the results of that survey and its meaning to medical negligence insurance, see McAtee, *Malpractice Insurance*, 64 *Best's Ins. News*, No. 4, pp. 61 et seq. (August 1963).

<sup>14</sup> 189 *J. A. M. A.*, No. 11, pp. 859 et seq. (Sept. 14, 1964).

<sup>15</sup> See *Id.* at 861.

<sup>16</sup> *Id.* at 860. Since the A. M. A. data shows that there is "less than one claim for every 270,000 physician-patient visits, an interesting comparison (Continued on next page)

It is important, however, that the legal risks for physicians not be exaggerated. Every profession has its risks, and the risk of liability claims is one which must be borne by the medical profession. In the practice of medicine some avoidable mistakes are bound to occur. When injury to a patient results, it should be compensated in a just and reasonable manner.

Practitioners in this area might be interested to know that the percent of physicians reporting any claim history in Ohio is significantly below the national average.<sup>17</sup>

The disposition of malpractice claims is also interesting. The 1956 survey showed that only 32.4% of all claims were settled by the payment of any amount whatever, which contrasts vividly with the experience of most attorneys, that general personal injury claims are settled in approximately 95% of the cases.<sup>18</sup> Among the cases that were actually litigated, the 1956 survey showed that only 18.7% resulted in verdicts for the plaintiff, which again contrasts strikingly with the experience of personal injury lawyers that, in general, the plaintiff wins at least half of all litigated cases.<sup>19</sup> A simple index of the magnitude and frequency of successful malpractice claims might be the premium for malpractice insurance. Although some physicians cry out that these rates are oppressive, they almost never come close to the appropriately adjusted rate for automobile liability insurance. We must remember that a physician treats patients for at least 5 times as many hours every day as he drives his car, yet his medical malpractice premium is nowhere near 5 times his automobile liability insurance premium.<sup>20</sup> The experience of some lawyers active in this field of practice indicates that there

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can be made to the doctor's vulnerability to automobile claims. Reliable statistics indicate that there is approximately one automobile collision for every 60,000 miles driven. Thus, a physician has less chance of incurring a malpractice claim by treating that next patient than he has of an automobile collision by driving his car the next 500 yards. See O'Connell, *Taming The Automobile*, 58 NW. L. Rev. 299, 323 (1963).

<sup>17</sup> See 189 J. A. M. A., No. 11, p. 860 (Sept. 14, 1964).

<sup>18</sup> See, *Id.* at 861.

<sup>19</sup> See, *Id.* at 860; McAtee, *Malpractice Insurance*, *op. cit. supra*, note 13, at n. 11. Verdicts and settlements seldom exceed \$5,000.00. See, *Medical Economics*, Vol. 32, No. 8, pp. 178, 185 (May 1955).

<sup>20</sup> See McAtee, *op. cit. supra*, n. 13, pp. 61-62; Lewis, *What's Your Best Buy in Malpractice Insurance?*, 32 *Medical Economics* (8), pp. 156 et seq. (May 1955).

are 2 to 3 cases against physicians for negligence in driving automobiles for every medical malpractice case.

Another source that encourages the reluctant medical witness to remain silent is that branch of the legal profession which actively defends medical malpractice cases. It is not at all unusual for defendant's counsel to contact each of the other treating physicians and to recommend that they avoid all discussions with plaintiff's counsel. Since he often represents the same malpractice insurer that protects the other witnesses, his advice is usually given considerable weight by those other physicians. The Chairman of the Malpractice Committee of the International Association of Insurance Counsel made this statement in that organization's Journal: <sup>21</sup>

In lecturing to the M.D.'s, I have always emphasized the need for mutual cooperation on the theory if the M.D.'s do not hang together they will most assuredly hang separately.

By using this tactic, defense counsel have been eminently successful in closing doors which one should ordinarily expect to find open and in closing minds which we would hope to find impartial.

Just this year the Federal Court in Cleveland refused to dismiss a lawsuit against the malpractice insurance company itself which alleged similar conduct.<sup>22</sup> In that case the plaintiff was a patient in a hospital and had sustained additional injury when the leg of his hospital bed broke, throwing him to the floor. In an action against the hospital's malpractice insurer, he alleged that defense counsel contacted the plaintiff's private physician on the pretense that he was investigating a potential claim against the doctor, that he induced the doctor to divulge privileged communications, and that he intimidated the doctor to discontinue treatment of the patient who had committed the unpardonable sin of making a malpractice claim against the hospital. The court first ruled that the alleged facts did assert a proper cause of action for damages against the insurer by having induced a breach of contract between the plaintiff and his physician. As the court noted, that physician was in a particularly able position to treat the patient by reason of his previous knowledge of the injury and medical background.

<sup>21</sup> See, Morris, *Malpractice: Medical—The Important Events of the Last Two Years*, 30 *Ins. Counsel J.* 44, 67 (Jan. 1963).

<sup>22</sup> *Hammonds v. Aetna Cas. & Surety Co.*, 237 F. Supp. 96 (N. D. Ohio, E. D. 1965).



The language of the court in upholding the claim for inducing a breach of confidential relationship, the second element of the claim, is interesting and worth stating:

The policy of the law is to promote a full and free disclosure of all information by the patient to his treating physician; this information entrusted to the doctor creates a fiduciary responsibility in regard to that information. Those confidences in the trust of a physician are entitled to the same consideration as a *res* in the control of a trustee, and the activities of a doctor in regard to those confidences must be subjected to the same close scrutiny as the activities of a trustee in supervising a *res*. Consequently this aspect of the instant case must be appraised in the line of principles governing third party complicity with a trustee's misfeasance.

Whether this decision or potential parallel decisions will inhibit the blatant attempts by defense counsel to stifle communications between the plaintiff's lawyers and the plaintiff's physicians is yet to be seen.

The last principal source of medical muteness is the law itself. The development of special legal rules in medical negligence cases has made the unavailability of medical testimony more significant, and consequently more prevalent. The absolute necessity that plaintiff produce a physician to testify as to the standard of care is to a large degree unparalleled in other litigation. The trier of fact is ordinarily able to determine reasonable care in designing complicated machinery or operating instrumentalities which he has never seen, with or without expert testimony, as to such a standard.<sup>23</sup> Yet, he is precluded by the law from determining whether a physician exercised due care on the basis of detailed testimony as to the acts which were done and extended explanations of available alternative procedures. Most jurors probably form their own opinions as to the reasonable standard of medical care in the circumstances, and disregard or weigh lightly an expert's statement as to the extent of care exercised by this medical community. Jurors are understandably more interested in the reasons for opinions as to a standard of care than they are in the professionally as-

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<sup>23</sup> While experts frequently do testify as to the standard of care in other fields of negligence law, there is not the same blind insistence that the standard can only be proved by expert testimony. Indeed, some courts prohibit such testimony in non-medical negligence cases on the theory that it is testimony on the ultimate issue and invades the province of the jury. See cases cited at 32 C. J. S., Evidence, Sec. 448; 7 Wigmore, Evidence, Sec. 1951 (1940).

serted opinions as to those standards. Yet the courts generally demand the expression of an expert opinion.<sup>24</sup> In so doing, the judicial system unduly emphasizes the importance of that opinion testimony. This emphasis induces physicians to weigh with great deliberation their decision whether to express an expert opinion adverse to another physician in the face of the extra-legal forces discussed above.

Some courts further complicate this already difficult situation by insisting that the expert opinion must be given by a member of the same geographical community. In today's medicine, physicians are guided by national medical knowledge, national specialty certifications, national board examinations, national drug literature, national medical societies, national medical publications, national hospital standards, and national medical conventions. It is not at all unusual for a physician to obtain his training in one community and to practice in another. Consequently, most courts are quite willing to allow testimony of a physician from a different geographical community, particularly when its medical facilities are not grossly different.<sup>25</sup>

The law also aggravates this problem in some jurisdictions by prohibiting cross-examination of the defendant-physician as to the standard of care in his community.<sup>26</sup> In virtually every

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<sup>24</sup> *E.g.*, *Ayers v. Parry*, 192 F. 2d 181 (3rd Cir. 1951), cert. denied, 343 U. S. 980, *Merker v. Wood*, 307 Ky. 331, 210 S. W. 2d 946 (1948), *Toy v. Rickert*, 53 N. J. Super. 27, 146 A. 2d 510 (App. Div. 1958); *Haggerty v. McCarthy*, 344 Mass. 136, 181 N. E. 2d 562, 94 A. L. R. 2d 998 (1962). See also, *Louisell & Williams*, cited *infra* at n. 25, Sec. 11.10. Some states permit the use of learned treatises to supply at least some evidence of the standard of care, by statute or case decision. *Mass. Gen. Laws Ann.*, Ch. 233, Sec. 79C (1959); *Nev. Rev. Stat.*, Sec. 51.040 (1961); *Stoudenmeier v. Williamson*, 29 Ala. 558 (1857); *Stone v. Proctor*, 131 S. E. 2d 297, 259 N. C. 633; 99 A. L. R. 2d 593 (1963).

<sup>25</sup> See Annotation, 8 A. L. R. 2d 772; *Louisell & Williams*, *op. cit. supra*, note 10, Sec. 8.06; *Riley v. Layton*, 329 F. 2d 53 (10th Cir. 1964). Cf. *Wis. Stat.*, Sec. 147.14(2)(a) (1961). These difficulties are further enlarged for the lawyer who is precluded from compelling production of hospital records before suit is filed. Compare *Wallace v. University Hospitals*, 84 Ohio L. Abs. 224 (Ct. App. 1960), appeal dismissed as moot, 171 Ohio St. 487 (1960), with *Phillips v. Mercy Hospital Ass'n. (Stark Co. App.)*, appeal dismissed as moot, 2 Ohio St. 2d 86 (1965). Where the hospital declines to make the records available before suit, and a court will not compel their production, the patient's lawyer is prevented from examining the records in determining whether a negligence claim has merit. He must then file a suit which may later prove groundless and from which he may find it difficult to withdraw. Both professions suffer from this situation.

<sup>26</sup> See *Louisell & Williams*, *op. cit. supra*, note 10, at n. 25, Sec. 11.10; *McCord*, *The Care Required of Medical Practitioners*, 12 Vand. L. Rev. 549, 619 (1959).

other negligence action, an expert defendant can be asked what procedures and techniques are used by the industry or profession generally.<sup>27</sup> When the defendant-physician cannot be asked the same question, the courts are needlessly demanding that some other physician describe that standard. In many cases the standard of care is not truly an issue, and the conflict rests on a factual dispute as to what was done. But even in these cases, plaintiff's counsel must seek out another physician to set that indisputable standard before the court, unless he has the power to compel the defendant to admit a proposition which he would be totally unwilling to deny. Thus, again, the law in some jurisdictions has become an instrumentality to enhance beyond proportion the need for expert medical testimony, and has thereby strengthened the resolution of those who would discourage such testimony.

The solutions to this problem are not open or obvious. Some efforts can be made to eradicate the sources with the hope that the problem will diminish as the pressures for its existence disappear. From a short term viewpoint, the lawyer representing a claimant in a medical negligence case must accept the burden of looking for an expert witness. Sometimes the claimant's other treating physicians can and do serve in this capacity. Sometimes physicians from another city may serve this purpose. Occasionally, a physician is willing to testify in a case against an osteopath, and pharmacologists or toxicologists may be willing to testify in cases against physicians. Academic leaders in medical schools or hospital administration are not quite so severely subject to social pressures of the medical society, and may be more willing to speak their minds openly. Study in the medical library can reveal the names of potential witnesses when counsel reviews their articles in the journals. The attorney's own doctor friend could be the necessary witness.

In jurisdictions which use a panel of so-called "impartial medical witnesses," this may be one potential source of testimony. Such a panel has been establishing in Cleveland, but it can be called upon only when both sides agree.<sup>28</sup> However, the

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<sup>27</sup> The custom and practice of the industry is a subject for fact testimony and does not ordinarily require expertise beyond familiarity with the practices of members of that industry or trade.

<sup>28</sup> See Rules of the Court of Common Pleas of Cuyahoga County, Ohio, Rule 21-B ("Pre-Trial Medical Plan") (effective Nov. 9, 1959). The rule

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defendant is generally opposed to any reference of a malpractice matter to that impartial medical panel, believing that he can otherwise effectively prevent the claimant from obtaining a competent witness to support his position. Sometimes a request to the medical academy will receive some attention, but medical societies often decline to involve themselves. Here is what the committee head of one county medical society committee wrote when he was supplied the relevant facts of a potential claim with appropriate photographs and asked for their assistance in mediating such a case:

It is the policy of our group to function as intermediary between patient and doctor when so desired by both. We do not consider claims by third parties and most particularly not when legal counsel is involved. By the time the latter has entered the scene, matters have progressed beyond the point where we can be of service.

If a case involving a similar claim of malpractice has been adjudicated in the same jurisdiction, a search of the court records can reveal the name of the physician who testified for that plaintiff. Having spoken out once, he may be willing to do so again. When all else fails, some counsel have attempted the use of blind or mass subpoenas. Numerous specialists in the field invoked are subpoenaed to come to court even though they refused to speak to the plaintiff's counsel about the subject. Manifestly, this is a dangerous route and may well produce more adverse testimony than favorable testimony, but, at this juncture, the attorney is "grasping for straws" to preserve a case that he firmly believes to be meritorious.

From a long range viewpoint, additional efforts can be made

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does not expressly require approval of all parties to the use of the medical panel, but this is the practical effect of the following requirement in the rule:

Before a Pre-Trial Judge shall order an examination and report by a panel of medical experts as provided herein, the parties, by their respective counsel shall stipulate in writing (1) that in the event the cause is tried, neither side shall make any reference to the fact that a medical plan had been utilized at or during pre-trial or to the fact that any medical witness appearing at the trial had previously served as such panel member; and (2) that in the event of a breach of such commitment the trial Judge shall be authorized to immediately declare a mistrial.

In addition, it can never be assumed that a particular physician (or panel of physicians) is necessarily impartial, since his own attitudes, background and experience must affect his judgment. See Manning, Disability and the Law, p. 37 (Congress of Neurological Surgeons 1962).

to reduce the sources of the problem. Professional medical pride will be aided if counsel and the courts will cease to refer to such cases as "malpractice claims." The words "malpractice" and "guilty" connote general incompetence and malevolence. Too many jurors (and too many doctors) are fearful that a finding of "guilty" will cause the good doctor to lose his right or ability to continue his practice, and too many fear that "malpractice" is a description of overall general inability to treat any patient in any manner in the future. But the same physician who can fail to stop at a stop sign through momentary neglect can likewise make an error on a prescription or forget to read a hospital chart. The avoidance of the term "malpractice" is aided by insisting that the lawsuit is one for *negligence* and that the standard of practice of the medical community is merely evidence which goes to the question of negligence.

The physician's fears may be somewhat alleviated if the truth about medical negligence claims is emphasized. The Bar should begin by an active and determined program of evangelism among individual doctors and medical societies which will explain to them the true volume of malpractice litigation, the unlikelihood of hazard to a careful physician, and their moral obligation to support such litigation in advancing their own profession. Section 4 of the "Principles of Medical Ethics" adopted by the House of Delegates of the American Medical Association in June, 1957, provides: <sup>29</sup>

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession, and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of other members of the profession.

Doctor Norman A. Welch, President of the A. M. A., in a statement to the state trial judges in New York City on August 8, 1964, said: <sup>30</sup>

It is entirely ethical for a physician to testify for either the plaintiff or the defendant in personal injury litigation, in-

<sup>29</sup> Principles of Medical Ethics, Ch. III, Art. I, Sec. 4, 167 A. M. A. J. 20 (1958).

<sup>30</sup> See, Welch, Medical Testimony and Professional Liability, Ins. Law J. No. 502, p. 673 (Nov. 1964). See also, Stetler, Medicolegal Professional Cooperation, 441 Ins. L. J., pp. 633-38 (Oct. 1959).

cluding malpractice suits, providing his testimony is objective, honest and in a field of medicine in which he is knowledgeable.

If all else fails, counsel might point out that the malpractice defense lawyers, who are the chief harbingers of doom on this subject, are equally vocal in decrying an allegedly increasing level of malpractice claims against lawyers.<sup>31</sup> While many law offices carry professional liability insurance to protect their clients if they should make an error, those lawyers are certainly not shaking with fear and would not refuse to testify that another lawyer's conduct was malpractice, when such was their honest opinion.

Some communities have established malpractice review committees of physicians and claimants' attorneys. These committees can be helpful to both the legal and medical profession by discouraging unfounded malpractice claims, while assuring that able witnesses will be provided in support of well-founded claims. The success of these committees depends upon the confidence of both the medical and legal communities in their fairness to all concerned.

Finally, reform of the law itself can do much to relieve this conflict. Some courts have eliminated the need for expert medical testimony as to the standard of care necessary in the circumstances by extending the doctrine of *res ipsa loquitur* or by concluding that the standard is "common knowledge."<sup>32</sup> Each of these approaches has some merit, but it tends to use an artificially created legal doctrine to attack an equally artificial legal doctrine.<sup>33</sup> If medical negligence cases were not treated differently from all other negligence cases, so that the jury would itself be able to determine a reasonable standard of care, on the basis of evidence as to available alternatives, courts would

<sup>31</sup> See, e.g., Morris, Report of the Malpractice Insurance Committee, 30 Ins. Counsel J. 404 (July 1963); Hutcheson, Lawyers, How Is Your Malpractice?, 30 Ins. Counsel J. 423 (July 1963).

<sup>32</sup> See Annotations, 82 A. L. R. 2d 1262, 1269-1270; 83 A. L. R. 2d 53, at 81, 89, 93 (dentists); 76 A. L. R. 2d 788 (ear treatment); 93 A. L. R. 2d 313 (female organ treatment); 88 A. L. R. 2d 309 (male urinary tract treatment); 97 A. L. R. 2d 525 (as ground for directed verdict for plaintiff); c. f., 99 A. L. R. 2d 610 (insanity treatment); 99 A. L. R. 2d 1336 (obstetrical treatment). See also Brophy, Highlights on Res Ipsa in Malpractice Cases, 502 Ins. L. J., pp. 645-51 (November 1964). See also, Morris, *op. cit. supra*, note 21, at pp. 48-50.

<sup>33</sup> See Note, Malpractice and Medical Testimony, 77 Harv. L. Rev. 333 (1963).

not have to stretch other legal doctrines. There is no reason why a court should have to find that the defendant retained complete control over a situation in which the alleged harm would not result without negligence, in order to permit the case to be decided by a jury. There is likewise no reason for a court to itself determine whether the standard of care is one of "common knowledge" for a particular procedure, before permitting the trier of fact to decide that very issue. Certainly, no jury should be authorized to find that the defendant-physician was negligent without evidence as to what was done and what could have been done under the circumstances. However, arbitrary insistence on an expert medical opinion as to an ultimate issue of fact can be a positive disservice to a fair adjudication in this type of case. And, when that insistence is compounded by requiring that the opinion be rendered by a physician from the same city and ordering that the defendant himself may not be asked to express an opinion on this subject, the courts defeat the very purpose they seemingly would want to accomplish.

Since the litigation of medical negligence cases is necessarily an adversary procedure, changes in attitudes or techniques of defense counsel are probably not feasible. Indeed, there is some doubt whether an effort to restrain defense counsel might be an unwise invasion of their role as advocates. This does not mean that such counsel have a *carte blanche* to employ unscrupulous devices for the advancement of their cause. Similarly, the likelihood that the legal profession will have a decisive impact on reforming the attitudes of the physicians is not great. Nevertheless, efforts should be made in each of these directions. The main thrust of reform would seem to lie in modification of the legal rules unduly enhancing the conspiracy of silence. This would be a slow but worthwhile process.